DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

FEB - 4 2003

Grantland Johnson
Secretary
Health and Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

Dear Mr. Johnson:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving California's Selective Provider Contracting Program (SPCP) waiver request for a two-year period effective January 1, 2003 through December 31, 2004. The SPCP waiver is authorized under section 1915(b)(4) of the Social Security Act (the Act) contingent upon meeting the conditions described below. This approval provides for the waiver of the following sections of the Act:

- 1902(a)(1) - Statewideness;
- 1902(a)(5) - Single State agency specifically to authorize California Medical Assistance Commission hospital contract negotiations;
- 1902(a)(13)(A) – Public Process for Rate Determination;
- 1902(a)(23) – Freedom of Choice; and
- 1902(a)(30)(A) –State Plan Hospital Payment Limit (but only to the extent that it requires SPCP hospital's to be paid under the methodologies set forth in the approved State plan).

Approval of this waiver renewal request is in accordance with the requirement that the project will be cost effective, will not substantially impair access to care and services of adequate quality, and will not restrict emergency services or family planning services. California may request that this authority be renewed and should submit its request for renewal ninety days in advance of the expiration date.

Approval of this request is contingent upon the following conditions:

1. Total payments (both per diem and supplemental) made under the SPCP during each waiver year, must not exceed the applicable State-wide institutional upper payment limit (UPL) per 42 CFR Part 447 and the allowable transitional excess amount.[1] The UPLs for the three categories of inpatient hospitals within the SPCP waiver (Federal

[1] The total State-wide UPL for non-State hospitals, State hospitals, and private hospitals are $4,571,645,066 in SFY 02-03; $4,744,572,706 in SFY 03-04; and $4,926,396,184 in SFY 04-05

2. and State dollars), which have been calculated on a State fiscal year (SFY) basis, are as follows:

	SFY 02-03	SFY 03-04	SFY 04-05
Non-State government-owned	$1,428,061,525	$1, 554,016,551	$1,691,080,811
Transition Excess	$794,515,218	$675,337,935	$556,160,653
State government-owned	$435,369,685	$ 469,197,910	$50 5,654,587
Privately-owned	$1,889,000,000	$ 2,019,000,000	$2,143,939,657
Total SPCP UPLs	**$4,546,946,428**	**$4,717,552,396**	**$4,896,835,708**

3. The UPL regulations require application of State fiscal year data to determine the allowable UPL. The SPCP waiver renewal, however, operates under a calendar year (CY) period. Thus, the SPCP UPL inpatient hospital limits have been adjusted to be consistent with the CY operation of the SPCP waiver renewal in order to reflect allowable spending under the waiver. In order for the State to make the allowable supplemental payments applicable to SFY 02-03, the CY limits were prorated to accommodate a temporary moratorium on supplemental payments during CMS' review of the SPCP waiver renewal.

4. Based on the CY UPLs, the maximum total payment and the maximum supplemental payments to hospitals in the SPCP waiver may not exceed the following (Federal and State dollars in millions):

	CY 2003	CY 2004
Supplemental payments	$ 2420 *	$ 1807**
Total Payments	$ 5193	$ 4807

* 0.7979 of SFY 02-03 allowable supplemental payments; 0.50 of SFY 03-04 allowable supplemental payments.

**0.50 of SFY 03-04 allowable supplemental payments; 0.50 of SFY 04-05 allowable supplemental payments.

5. To ensure that total payments do not exceed the SPCP limits, the State will monitor SPCP payments and provide the CMS Regional Office within sixty days after each quarter the following:

   a) Actual data, using date of payment, for each contract hospital for:
      - Per-diem payments
      - Supplemental payments

   b) An explanation describing how the past per diem and supplemental payments and future payments will not exceed the total and supplemental payment limits established.

The first report will not be due until 90 days after the first quarter that the waiver has been active to allow for creation of this report and the process needed to issue it.

6. All aggregate payments to hospitals including contract rates and supplemental payments must not exceed each individual hospital's aggregate Medicaid customary charges as defined by 42 CFR 447.271. To this end, the State must submit an annual report for SFYs 00-01 through 04-05 of each hospital's payments and customary charge limits, to include only the hospitals receiving supplemental payments. This report should include:

   a) The customary charge limit per hospital based on paid claims data; and
   b) The total payments made to each individual hospital delineated by contract rates and supplemental payments.

   This report is to be completed on a SFY basis and is due not later than 15 months after the close of the particular SFY, in order to include the most complete data.

7. There can be no contractual agreement between the State and a contracting hospital that requires or suggests hospital payments for non-Medicaid allowable services. All Federal funds reimbursed to the State under this program must be for Medicaid inpatient hospital services as defined in the approved State plan.

8. The State must inform CMS in writing of any new supplemental payment program that it intends to fund using Federal matching dollars. The description of any new supplemental payment program should include:

   a) How the monies would be distributed to the benefiting hospitals;
   b) How the program is funding Medicaid State plan services; and
   c) All relevant State legislative language.

9. The State should continue to send CMS a copy of the annual report to the legislature including a general description of the supplemental payment program(s).

10. No changes may be made to these agreed upon terms and conditions (including specific spending caps) without written permission from CMS.

CMS will issue a disallowance of Federal financial participation (FFP) of the $8,204,416 overpayments made to hospitals above their customary charge limits during the previous SPCP waiver period. This information was disclosed to CMS by the State during its review of the SPCP. This disallowance is subject to the normal appeals process.

We understand that much of the information requested above is considered proprietary. Please be assured that CMS will work with the State to protect the confidentiality of this information.

I would like to wish you success in the ongoing administration of the SPCP waiver program. In addition, I would like to thank you and your staff for working with us during the course of our review of this renewal request.

If you have any questions, please feel free to contact Richard Fenton, Acting Director, Family and Children's Health Program Groups, CMSO, at (410) 786-5647.

Sincerely,

Thomas A. Scully